STRATEGIC PLAN PROGRESS REPORT - 2014

Cabinet for Health and Family Services (CHFS) -- 53

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VII. Measurable Goals, Objectives & Key Performance Indicators

A. Create Careers and Economic Opportunities

A1. Establish practices that create a positive business environment within applicable statutes, regulations for all customers.

A1.1. Develop new communication channels.
A1.1.1. Use new and existing technologies to connect and interact with customers and the public including web pages, email, social media and mobile devices.
A1.1.2. Develop accessible information technology solutions that accommodate persons with disabilities, limited literacy, and those who speak English as a second language.

Department for Community Based Services (DCBS): *In September 2011, on behalf of CHFS, DCBS was awarded a participation grant under the Supplemental Nutrition Assistance Program (SNAP), formerly known as the Food Stamp Program, by the U.S. Department of Agriculture-Food and Nutrition Service. Anticipated outcomes of the grant are improved access and retention of eligible households in SNAP. DCBS and its CHFS partners launched the SNAP web portal in March 2013 which provides citizens the ability to prescreen to check for potential SNAP eligibility, begin the application process, report changes, receive notices electronically, and submit periodic review forms. In addition to the SNAP web portal, DCBS has implemented a complete business process redesign that, in part, provides citizens the ability to access many services through a statewide toll-free call services number. When citizens call this number, a trained caseworker can handle many situations that previously required an in-person visit, including benefit application, recertification, case change reporting, benefit inquiries, etc. This change allows access to agency services for all populations in a more convenient and efficient manner.*

Medicaid: *The Department for Medicaid Services (DMS) has restructured with a structure that more closely aligns "like" services (e.g. all phone services are now handled by a dedicated customer service team, all fiscal and financial issues are handled by a dedicated financial management team, etc.) which improves the efficiency of DMS and makes for a better customer experience. DMS commissioned a vendor to work on Project MORE (Medicaid Organizational Readiness for Expansion). The purpose of the project*

was to analyze the organization and make recommendations to increase effectiveness of staff members and teams.

Department for Income Support (DIS): *Kentucky citizens may apply for Social Security Administration (SSA) disability benefits through web portal, now with electronic signature acceptance. Kentucky Disability Determination Services (DDS) leverages Tele-Interpreter Information Service (TIS) and the Telecommunication Device for the Deaf (TDD) communication services to reach client populations. As of July 1, 2012, the agency-automated phone greeting offers bi-lingual menu options. Beginning February 27, 2012, custodial and non-custodial parents may use the Child Support Customer Service Web Portal to apply for services and access their account. The Customer Web Portal is ADA compliant as well as bilingual (Spanish).*

Office of Administrative and Technology Services (OATS): *OATS has established a strategic technology architectural model Quality Health Infrastructure (QHI) designed to promote streamlined convenient access to CHFS systems and services and includes the development of a single patient and provider portal through which consumers and providers of healthcare and benefit services can access the information and services they are authorized for with a single logon and user ID. Once the SharePoint 2013 upgrade occurs, OATS will work with program agencies to redesign the CHFS internet site to provide more effective and efficient access for clients and providers seeking information. Work on these initiatives is ongoing.*

Department for Public Health (DPH): *DPH has undertaken a review of all Information Technology systems and is determining short and long-term plans to address system changes that are critical to health access and utilization and necessary to better serve the Local Health Department and the citizens of the Commonwealth.*

In addition, Kentucky is participating in the National Governors Association (NGA) Policy Academy: "Developing State-level Capacity to Support Super-Utilizers" focused on assisting states in creating the regulatory environment, data systems, workforce, payment and financing structures, and stakeholder relationships to support super-utilizer Emergency Room (ER) care models.

Thirteen percent (13%) of all utilizers of the ER are seen four or more times per year and account for 41% of ER costs ($138 M). Medicaid recipients who utilized the ER 10 or more times represented 1% of the total number using ER services, but account for 10% of all ER costs ($33.8 M). The group with 10 or more visits per year repeated this activity almost 90% of the time. "Superutilizers" typically have a constellation of chronic medical illnesses, and frequently suffer with mental illness and/or substance use disorders. Additionally, social barriers contributed to driving high preventable utilization of care in acute care settings. Clinical and Operational Goals include:

- *Reduce Inappropriate ER Use*
- *Development of Continuous and Impactful Messaging*
- *Improve Patient Health*
- *Improve Health Care Systems*
- *Ensure Effective Flow and Availability of Data and Information*
- *Develop a Functional and Sustainable Model for the Future*

A2. Enhance the workplace environment to support and retain a

knowledgeable and experienced workforce.

A2.1. Improve the quality of performance evaluations to enhance communications between staff and supervisors.
A2.2. Conduct staff training to ensure compliance and the use of best practices, including use of on-line training modules.

DPH: *DPH staff are asked to complete a Self-Assessment via the TRAIN Learning Management System annually to identify Public Health competencies the individual may improve upon as well as competencies the organization desires staff to strengthen especially as the Department moves towards accreditation. The TRAIN Learning Management System houses competency based training that bridges identified competency needs. Every DPH employee has a TRAIN account which can be accessed at any time to find needed trainings, work through training plans and core curriculum and also document completed trainings meeting licensure requirements, accreditation documentation and grant deliverables. The Self-Assessment will be offered annually and over time the cycle of assessment and training will align with employee evaluations and workforce development initiatives.*

In addition to the self-assessment initiative DPH has established a Wellness Committee composed of representatives from each division. The committee has worked on a number of initiatives to help enhance the employee's work experience and to develop a culture that encourages a healthy workplace. Employees had an opportunity to complete a survey regarding workplace needs, participate in an Exercise with Ease class and the Better Bites initiative designed to offer healthy choices in the cafeteria.

DIS: *The DDS Supervisory Learning Institute was implemented on August 1, 2012 to equip supervisory staff with tools for success. Curriculum includes online and traditional classroom exposure to leadership concepts and opportunities for practical application. Throughout FY 2014, DDS offered 26 in-house programmatic continuing education sessions to strengthen staff knowledge base. Best practices were shared with sister agencies through Share Point technology. Staff were trained on-line for system enhancements. DIS obtained MOBI software that assists staff in learning new material and procedures. MOBI enables real-time evaluation of the effectiveness of training methods so exchange of information can be altered if necessary.*

DIS: *The Child Support Enforcement (CSE) program uses on-line training for the IRS safe guarding. CSE will also use this for the upcoming solutions.*

Medicaid: *DMS is striving for more inclusive team meetings, more sharing of ideas and information – with the intention of engaging our associates. DMS is building a Kentucky Medicaid University in partnership with Eastern Kentucky University (EKU). When completed, this robust and certified training syllabus will enhance workforce knowledge and make them even more valuable to the organization. Additionally, the courses will be available to any interested party through EKU's online learning portal. Anyone wishing to learn more about Medicaid both on a federal level and statewide may purchase the ten course program and receive a certificate of completion from EKU.*

OATS/DCBS/KOHBHIE: *The Cabinet is currently replacing the Kentucky Automated Management and Eligibility System (KAMES) with an integrated system that will accept applications via internet and link to other major Cabinet information systems. KAMES is a 20-year-old legacy mainframe system. It is labor, time, and cost-intensive to maintain and uses COBOL computer language, which is no longer widely used.*

The new Eligibility Systems Integration Services (ESIS) will devise a flexible model for implementation of eligibility determination rules, which will allow for greater ease in the future in implementing rule changes resulting from new regulatory or legal mandates. This project is being built on existing Health Benefit Exchange/Medicaid Eligibility System functionality.

The ESIS project was approved in October 2013 by the Capital Projects and Bond Oversight Committee. This new capital information technology project will enhance the foundational components of the new Medicaid Eligibility System to integrate other health and human services programs that serve a large common population. These additional programs include: Supplemental Nutrition Assistance Program (SNAP aka Food Stamps); Temporary Assistance for Needy Families (TANF); Women Infants and Children (WIC) Food Program; Low Income Home Energy Assistance Program (LIHEAP); and Medicaid Waiver programs.

Implementation of the new system is planned for December 2015.

A3. Support individuals to acquire and maintain employment.

A3.1. Provide job training and work supports to assist families to self sufficiency.

A.3.1.1. Achieve a statewide work participation rate of 50% of participants in the Kentucky Transitional Assistance Program (Temporary Assistance to Needy Families) under federal and state program rules.

DCBS: *The data submitted for Federal Fiscal Years 2012 and 2013 met the anticipated work requirement which Kentucky must attain based on the state's calculation of the caseload reduction credit. The data and the state's calculation of the caseload reduction credit are still pending approval of the U.S. Department of Health and Human Services (DHHS). Kentucky's last update for the all participants rate is 55.6% for March 2014 with an average rate of 56.4% for the first two quarters of Federal Fiscal Year (FFY) 2014. The actual rate determined for FFY 2014 will be adjusted by the caseload reduction credit to establish the state's federally assessed rate.*

A.3.1.2. - Maintain statewide participation rate of 90% for two-parent family participants in the Kentucky Transitional Assistance Program under federal and state program rules.

DCBS: *The data submitted for Federal Fiscal Years 2012 and 2013 met the anticipated work requirement which Kentucky must attain based on the state's calculation of the caseload reduction credit (final FFY 2012 and 2013 approval is pending at the U.S. Department of Health and Human Services. Kentucky's last update for the two-parent rate includes a rate of 56.2% for March 2014 and an average rate of 59.6% for the first two quarters of Federal Fiscal Year (FFY) 2014. Although 90% is the stated goal in the federal statute, other provisions of the law allow the federally-assessed rate to be adjusted by a state's caseload reduction credit. The actual rate determined for FFY 2014 will be adjusted by the caseload reduction credit to establish the state's federally assessed rate.*

B. Create a Healthier Kentucky

B1. Improve access to quality and affordable healthcare.

B1.1. Increase access to and the exchange of electronic health information.

B1.1.1. Implement policies and procedures to preserve individual privacy and maintain security of personal health information.

OATS: *Progress has been made to implement Direct Secure messaging and a Patient Electronic Medical Record (EMR) as added functionality of the Kentucky Health Information Exchange. The Patient EMR is set to be piloted with select providers in October 2014. Direct Secure messaging has been implemented and has 160 providers utilizing the service. These new services allow providers and patients to have access to electronic medical records and provide secure email communications between providers and patients. These capabilities will increase the incentive for employers to locate or remain in the Commonwealth and provide current and prospective employees and their families more confidence in their health care environment.*

DPH: *DPH, working with the Office of Administrative and Technology Services is pursuing an Electronic Health Records system to enhance access to health records and pursuing initiatives that will strengthen access to health records through the connection of newborn screening and the immunization registry. Also, DPH through the Office of Vital Statistics has been aggressively pursuing the implementation of the electronic Death Registry which is scheduled to go live January 2015.*

B1.1.2. Increase the number of providers and participants in the electronic health exchange.

Kentucky Office of Health Benefit and Health Information Exchange *(**KOHBHIE):** The Kentucky Health Information Exchange (KHIE) facilitates the safe, secure electronic exchange of patient health information among participating providers and organizations throughout the state. This effort grew out of the push for a nationwide electronic health network to convert paper medical records to electronic data that can be shared more readily.*

KHIE is a secure, interoperable network administered by KOHBHIE and supported by the OATS technical team. It connects hospitals and providers in the state to a common framework for the exchange of patient information. KHIE now has over 600 signed Participation Agreements, representing over 2,200 provider locations across the state with over 1,000 "live" connections.

The system supports e-prescribing, patient demographics, lab results, radiology and transcription reports, past medical diagnoses, dates of services and hospital stays. It also offers the capability to communicate reportable diseases, reports to the Cancer Registry, Syndromic Surveillance by reporting to the Centers for Disease Control and Prevention (CDC) through the BioSense environment, and provides immunization data to the statewide immunization registry.

KHIE is now providing Direct Secure messaging, a simple, secure, scalable, standards-based way for KHIE participants to send authenticated, encrypted health information directly to known, trusted recipients using

an Internet based healthcare information service provider (HISP). KHIE is also developing a Personal Health Record (PHR)/Patient Portal.

The Medicaid Electronic Health Record (EHR) Incentive Program is working on Medicaid Meaningful Use Stage 2. The EHR Incentive Program provides incentive payments to eligible professionals, eligible hospitals and critical access hospitals (CAHs) as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology. Kentucky has paid over $175 million in federal funds to hospitals and providers in EHR incentive payments.

Medicaid: *DMS continues to support the roll out of the KHIE by providing financial support for those providers that participate.*

During the summer of 2014, DMS is conducting 8 regional meetings throughout the state that will educate over providers statewide on Medicaid, Public Health, Behavioral Health, Community-Based Services and other components parts of the Cabinet.

B1.2. Expand the continuum of services, supports, and resources to allow individuals to live in their communities.

B1.2.2. Pursue options and seek federal and state resources to provide additional supports to individuals with disabilities to enable them to live in their communities.

Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) - Children's Services: *DBHDID was awarded a $4 million, four-year cooperative agreement with the Substance Abuse and Mental Health Services Administration (SAMHSA) to enhance services and supports for children and youth with behavioral health needs, and their families. The Department is partnering with child-serving agencies to enhance the service delivery system for children and youth with behavioral health needs by advancing the development of a coordinated, comprehensive service delivery system that involves youth and families at all levels. Youth outcomes tracking will begin in Fall 2014.*

DBHDID was awarded a $3 million, three year cooperative agreement with SAMHSA to divert youth with substance use and co-occurring mental health and substance abuse issues from juvenile justice to appropriate services. To date, 130 youth have been served in the two pilot communities.

In an effort to maximize funding opportunities, DBHDID submitted two SAMHSA grants, one focused on transition-age youth and one for suicide prevention and also partnered with the Kentucky Department of Education to respond to SAMHSA's Project AWARE grant opportunity. If funded, each of these grants will provide additional community-based resources to support children and youth to remain in their homes and communities.

DBHDID - Adult Services: *During SFY 2013, DBHDID contracted with Kentucky River Community Care (one of the Regional Behavioral Health Boards) to operate Caney Creek Rehabilitation Complex, with the goal of moving all residents into permanent, community-based housing. This contract is performance based and mandates that community housing for this population must follow supportive housing principles, utilizing SAMSHA's Permanent Supportive Housing Toolkit. In addition, Caney Creek staff must utilize Assertive Community Treatment (ACT) as a method for meeting the needs of those residents who end up living in the community. This creates another less restrictive living environment for adults with Severe Mental Illness.*

As of August 2014, forty-seven (47) of these individuals are residing in the community. The DBHDID will also work with the other specialized personal care homes, during SFYs 2014 and 2015, to develop supported housing plans as appropriate, and assure that plans are person centered and individualized by regional strengths and needs.

In August 2013, the CHFS entered into a settlement agreement with Kentucky Protection and Advocacy to develop and implement services to allow 600 individuals with severe mental illness (SMI), who are residing in or at risk of entry into Personal Care Homes (PCH), to live in the community. By October 2014, the Cabinet's goal is to provide assistance to 100 individuals, by October 2015, to 200 additional individuals, and by October 2016, to 300 additional individuals. To operationalize this, the 14 Regional Boards will provide these intensive community services:

- *Assertive Community Treatment (ACT) is an outreach-oriented service delivery model for people with Severe Mental Illness (SMI), which delivers comprehensive community-based treatment, rehabilitation and support services to consumers in their homes, at work and in community settings using a 24-hour a day, 7 day a week team approach.*
  - *Supported Housing provides an array of activities and services to assist individuals with SMI to choose, obtain and maintain regular housing in the community through accessing subsidies, locating suitable housing, negotiating leases, acquiring household items, moving the individual into the residence, and teaching housing related living skills.*
  - *Supported Employment (SE) is an approach to vocational rehabilitation that emphasizes helping persons with SMI obtain competitive work in the community and provide the supports necessary to ensure their success in the workplace.*
  - *Peer Support is social and emotional support provided by persons having a mental health condition to others sharing a similar mental health condition in order to bring about a desired social or personal change and is developed around principles of respect, shared responsibility and mutual agreement of what is helpful.*

  As of August 2014, thirty-two (32) individuals have moved from a PCH to the community.

DBHDID - Intellectual and Developmental Disabilities (I/DD):

- *In January 2014, CMS announced a requirement for all states to review and evaluate current home and community based (HCB) service settings, including residential and nonresidential settings to ensure that individuals receiving services and supports through HCB services have full access to the benefits of community living and are able to receive services in the most integrated setting. All states that offer HCB waiver services must submit a transition plan to bring all HCB services and settings into compliance with the final rule. DBHDID is collaborating with other HCB services program staff to develop Kentucky's transition plan to incorporate these requirements into all 1915(c) HCB waiver programs.*

- *The full implementation of the Supports for Community Living Medicaid Waiver II program (SCL2) began in January 2014. SCL2 offers a variety of new services and supports to help enhance participant's access to the broader community including expanded options for Supported Employment, Community Access, Residential, behavioral supports, as well as opportunities to participant direct some non-residential or medical services and supports. Other changes through the SCL waiver program include:*

- *Standardization and regionalization of the decision making and review processes of human rights and behavioral interventions.*
- *A Direct Support Professional (DSP) credentialing program that offers multiple avenues to achieve credentials in specialized areas of support through demonstration of education, experience, or achievement of certification of competency from a recognized national accrediting agency to enhance the skills and knowledge base of the DSP workforce in the SCL provider community.*

- *DBHDID in collaboration with University of Kentucky's Human Development Institute is now working with seven SCL providers through an extensive training and mentoring course, Endeavor for Excellence (EFE) that is designed to enhance the capacity of providers to impact the lives of the people they support. The course focuses on the information, ideology, strategy and skill necessary to design and provide high quality human services in partnership with people with developmental and intellectual disabilities and their families.*

- *Community Belonging is a DBHDID training initiative that began in September 2012, that promotes the inclusion of citizens with disabilities to increase natural supports in the community and in the workplace while focusing on community agencies becoming more person-centered. Fifty-five (55) individuals from fourteen (14) Supports for Community Living (SCL) agencies across the state initially signed up to participate in this program designed to assist individuals in developing friendships and becoming an active part of their community. At the conclusion of Year 1 (October, 2013) of the three-year initiative, teams reported the following outcomes: 55 individuals started the program, 45 completed Year One. Of these 45 individuals, positive results were noted for 41 individuals in at least 4 areas: new community friends; community groups/associations; new valued social roles; and improved family relationships.*

- *The National Core Indicators (NCI) data from 2012 indicated that 21% of Kentuckians with I/DD engaged in moderate physical activity for 30 minutes a day at least three times a week, which is below the national average of 26%. To begin addressing overall health of SCL participants, a webinar for 210 SCL providers in August announced the "Health Messages" pilot project for up to 25 organizations, a collaborative effort with University of Illinois at Chicago's Rehabilitation Research and Training Center on Aging and Developmental Disabilities. This 12-week program, introduced in October 2012, is led by an individual receiving supports who is teamed with a direct support professional. Results were used to launch a collaborative effort with the Human Development Institute at the University of Kentucky (UK) and the University of Illinois-Chicago for pilot projects around an evidence based health and wellness curriculum and a pilot self-advocate led program at 14 provider agencies, impacting over 100 individuals on the SCL waiver. A Health Wellness Coordinator has been employed who will be focusing efforts on developing the groundwork for piloting the Health Matters curriculum developed from the University of Illinois at Chicago for health promotion for people with developmental disabilities across the state and continue promotion of engaging participants in meaningful physical activities as well as improved eating habits.*

- *Employment First - In conjunction with the Education and Workforce Development Cabinet's Office of Vocational Rehabilitation and Office for the Blind, DBHDID is developing standard policies and procedures for the provision of Supported Employment in Kentucky. As part of this process, DBHDID is involved in three different groups: ODEP's Community of Practice, The Employment*

Learning Community (ELC), and VisionQuest (school to work transition). Over the past 2 -3 months Employment First training has been conducted at two locations in Kentucky.

- *DBHDID has trained parents, participants, and families on the likely impact of wages on participants' benefits; participated in the development of Benefits Analyses for participant's with specific concerns; and have continued to help participants address incorrect assessments of patient liability including:*
  - *In-person training - "Unscrambling Myths: The Truth about Wages, Work, and Waivers," was conducted in 10 locations throughout Kentucky. Each training required 3 hours.*
  - *Over the past year approximately 120 participants have received direct assistance in determining the specific impact of wages or potential wages on their benefits in order to make an informed decision about their employment. Over the past year approximately 360 inquiries have been addressed regarding the correct application of Medicaid's share of Cost (Patient Liability) assessment.*

Implementation of Supported Employment in the SCL2 waiver - Opportunities have been provided to allow employment specialists, case managers, and rehabilitation counselors to interact more effectively to support participants through the delivery of in-person training, the use of community forums, and direct consultation.

- *Over the past year four full-day Community Forums were conducted in Kentucky involving approximately 240 participants.*
- *In-Person training – "Opening Doors: Employment Supports in the SCL Waiver" was conducted in 11 Kentucky locations as well as the National Association for Centers of Developmental Disabilities Conference. Each training required two and one-half hours.*

Quality Assurance –Tools and procedures have been developed that improve the likelihood of the provision of high quality supports. These tools are not limited to employment services but cover all services provided through the waiver.

- *The Focus Tool was redesigned taking into account the need to meet the expectations of Case Managers as well as BHDID's need to effectively monitor health and safety, outcomes, wellness, loneliness, and employment.*
- *Quality Indicator tools have been developed for all services and DBHDID continues to make revisions, conduct training, and plan for the initial testing of the product. DBHDID plans to move toward full implementation in Early 2015.*
- *DBHDID is developing tools to lead providers of each service to best practice in the areas of Staffing, Organization, and Operation.*

Beginning this Fall a recruitment presentation and accompanying materials will be designed and distributed to providers in order to educate local employers on customized employment and the positive impact it can generate. As a part of their commitment providers will commit staff persons to complete "train the Presenter "training before participating in the program.

B1.3. Enhance outcome measures relating to substance abuse treatment.

B1.3.1. Increase collaboration with behavioral health and substance abuse professionals on outcome measures.

DBHDID: *Community Mental Health Centers (CMHCs) are required to report the previous year's access and retention performance measures annually, and for each outcome below the state benchmark, they are required to report steps they will take to improve their scores. In FY 2014, 40% of the FY 2012 measures were at or above state benchmarks, up from 35.7% the previous year. Sixty-nine percent (69%) of the outcome measures improved compared to FY 2013 reports. The state as a whole improved in three of the four measures, and exceeded the current benchmark for two of the measures.*

Strategies reported by the CMHCs to increase access and retention included the following:

- *NIATx change projects*
- *Training and coaching staff on engagement skills (Motivational Interviewing, person-centered treatment planning)*
- *Reduction of intake paperwork on first appointment*
- *Increasing services: Intensive Outpatient Programs (IOPs) and groups, adolescent services, extended hours*
- *Follow-up calls and letters for no-shows and cancellations*
- *Maintaining call lists to fill cancellations and no-shows*
- *Client feedback program*
- *Case management to address client needs and barriers to treatment*
- *Pre-treatment group*
- *Trauma informed care training*
- *Using more evidence-based practices*
- *Promoting services in the community with in-person visits and brochures*
- *Increase staff in underserved rural locations*
- *Integrate mental health and substance use screening and assessments*
- *Reduce length of residential stay and refer to transitional program*

The DBHDID has added access and retention measures to the SFY 2015 CMHC contracts. For contractual accountability, the CMHCs can earn ½ of the allocated Substance Abuse Treatment funding by meeting the benchmarks for these measures.

B1.3.2. Utilize information available from the federal Substance Abuse and Mental Health Services Administration regarding national outcome measures and best practices for substance abuse treatment.

DBHDID: *During the contract period SFY2014, DBHDID collected information about standard assessment tools being used by the CMHCs. These included: The Global Appraisal of Individual Needs (GAIN), Substance Abuse Subtle Screening Inventory (SASSI), and the Addiction Severity Index (ASI). Additionally, several CMHCs were utilizing the UK Center on Drug and Alcohol Research web-based application as a supplemental tool to assist in the assessment process.*

During the CMHC contract period SFY 2015, CMHCs are required to report which evidence based practices are used with adults and adolescents with substance use and co-occurring disorders; the following were listed during SFY 2014:

- *Motivational Interviewing*

- *Living in Balance*
- *Seven Challenges*
- *MATRIX*
- *Seeking Safety*
- *Prime for Life*
- *Brief Strategic Family Therapy*
- *Brief Strength-Based Case Management*

During SFY 2015, DBHDID plans to sponsor opportunities for CMHCs to explore ways to implement Evidence Based Practices, particularly those related to opiate addiction and adolescent-specific services.

B1.4 Promote policies that support healthy communities and individuals.

DPH: *Governor Steve Beshear has made improving the health and wellness of Kentucky's children, families and workforce one of his highest priorities and has announced seven health "kyhealthnow" goals for the Commonwealth. Strategies to achieve those goals are being developed and implemented through executive and legislative actions, public-private partnerships and through enrolling more Kentuckians in health care coverage. For additional information on the "kyhealthnow" initiative click on the following link: http://governor.ky.gov/healthierky/kyhealthnow*

Field Code Changed

B1.4.1. Improve the health of disparate populations.

DPH: *The biennial Minority Health Status Report was released this year and provides quantifiable data that helps track progress and trends over time related to minority and underserved populations. It also identifies areas where data collection related to specific populations is lacking in order to focus programming and policy efforts on reducing the health disparity.*

B1.4.2 Develop a Healthy Kentuckians 2020 Plan.

DPH: *The goals and objectives have been drafted by a multidisciplinary workgroup and stakeholder input solicited over several months. An executive summary is being vetted for publication. Healthy Kentuckians 2020 aligns with the DPH mission, "To improve the health and safety of people in Kentucky through Prevention, Promotion and Protection" and provides a basis for the Kentucky State Health Improvement Plan, which promotes the DPH vision of healthier people in healthier communities.*

B1.4.3 Reduce chronic disease risk by decreasing youth smoking.

DPH: *According to the Youth Risk Behavioral Surveillance Survey (YRBSS) the rate of current smoking among youth has demonstrated a statistically significant decline since 2009:*

- *Middle school -- 9.8% (2009); 9.0% (2011); 6.4% (2013)*
- *High school – 26.1% (2009); 24.1 % (2011); 17.9% (2013)*
- *Kentucky's youth smoking rate (among high school students) declined significantly, from 24.1% in 2011 to 17.9% in the most recent YRBSS report (released July 2014 for 2013). This moves Kentucky from a 1st place ranking in youth smoking to 6th place, and means that Kentucky has met its Healthy Kentuckians 2020 goal of reducing youth smoking to 19% or less. However, Kentucky is still above the national average of 15.7%.*

- *Kentucky adopted legislation banning the sale of all types of e-cigarettes to minors. This will help curb first time cigarette users since e-cigarettes are considered to be a first step for minor smoking.*
- *DPH and CHFS will continue to support comprehensive smokefree legislation on state and local levels and encourage school districts to promote tobacco free campuses. Currently 34 out of 173 school districts are tobacco free districts.*

B1.5 Assess the Commonwealth's healthcare workforce and health facility capacity to meet needs of the population given the implementation of the Affordable Care Act.

B1.5.1 Coordinate the Cabinet's response to the recommendations made in 2013 reports regarding workforce and health facility capacity.

B1.5.2 Propose revisions to the State Health Plan to address health facility capacity issues.

Office of Health Policy (OHP): *The Cabinet contracted with a vendor to assess and make recommendations regarding the accessibility and availability of the Commonwealth's healthcare workforce and health care facilities. That report was completed in May 2013 and the facility report was completed in December 2013. These reports are being utilized by the Cabinet to explore legislative and administrative policy changes needed to increase the supply of health care professionals and facilities to improve population health. Kentucky is also participating in the National Governors Association's Policy Academy on Building A Transformed Health Workforce.*

DPH: *A statewide Healthcare Worker (HCW) program is being developed as well as the promotion of the use of telehealth to include teledentistry, and public health dental hygienists.*

B1.6 - To promote the efficient use of resources in health care delivery systems in the Commonwealth.

B1.6.1- Coordinate Cabinet policies regarding effective use of telehealth network in the Commonwealth.

B1.6.2- Promote evidence-based practices regarding integration of health service delivery.

OHP: *OHP is promoting expansion of integrated care, the systematic coordination of general and behavioral healthcare, as the most effective approach to caring for people with multiple healthcare needs. OHP also continues to support the expansion of the telehealth state network, including through planning of Health Homes for Medicaid patients under Section 2703 of the Affordable Care Act.*

DPH: *The Department continues to encourage the local health departments to offer telehealth and teledental services.*

B1.7 – Implement Medicaid expansion effective January 1, 2014.

Medicaid: *Effective January 1, 2014, Medicaid coverage was expanded to individuals and families at or below 138 percent of the federal poverty level. As of 4/12/2014, over 300,000 individuals are enrolled in new health care coverage including insurance and Medicaid expansion.*

B1.8 – Open the Medicaid behavioral health network to increase access to services for children and adults.

B1.9 – Expand the Medicaid benefit to include coverage for substance abuse.

Medicaid: *Under the Affordable Care Act, all Medicaid expansion states are required to cover behavioral health and substance use services through Medicaid. Kentucky DMS had covered behavioral health services through the Community Mental Health Centers (CMHCs) prior to January 2014, but with the increased Medicaid population, it was necessary to open up the behavioral health network to ensure the availability of additional providers. Kentucky DMS began authorizing independent licensed behavioral health providers, created a new licensed entity, the Behavioral Health Services Organization, and began covering treatment for substance use disorder.*

DBHDID: *During SFY 2013 and the first half of SFY 2014, the DBHDID worked closely with the Department for Medicaid Services (DMS) to attain processes and codes that allow DMS to be a funding source for several substance abuse services. In January 2014, the following were listed as DMS billable services thus more available to the individuals having disabilities living in the community.*

- *Residential Services for Substance Use Disorders – Short Term*
- *Residential Services for Substance Use Disorders – Long Term*
- *Screening, Brief Intervention, and Referral to Treatment (SBIRT)*

The goal during SFY 2015 is to track utilization of these services.

B2. Support quality physical and behavioral health care.

B2.1. Complete Medicaid eligibility decisions within 30 days of application for no less than 95% of applicants.

B2.1.1. Establish monthly reviews for timeliness.

DCBS/Medicaid: *Monthly audits of performance are being performed. The statewide application processing for Medicaid eligibility decisions has consistently exceeded performance standard with respect to the 30-day timeframe. In Federal Fiscal Year (FFY) 2013, 97.7% of Medicaid applications were processed within 30 days. For FFY 2014, 96.85% of applications were processed within 30 days.*

DIS/DDS: *As of August 2014, processed 98.4% of applications received for KTAP and Family Medicaid programs through partnership with DCBS. FY 14 processing time 25.7 days exceeds expectation.*

B2.1.2. Collaborate with Department for Medicaid Services and its managed care

contractors in system changes.

Medicaid: *Collaboration with the Managed Care Organizations (MCOs) is ongoing and productive. Numerous systems enhancements have been deployed to create a more efficient exchange of information. DMS has instituted monthly MCO Medical Director meetings coordinated by our Medical Director as well as monthly MCO Pharmacy Director meetings with our Pharmacy Director. The MCOs are invited to all Medicaid Advisory Committee (MAC) meetings to hear provider and member issues presented by committee. In collaboration with DBHDID, monthly meetings are held with the MCOs to report on program quality and outcomes. The MCOs have also worked with DPH to reimburse for services provided by public health dental hygienists. The MCOs submit timely reports on activities such as enrollment numbers, claims processed and denied, appeals, prior authorizations as well as good news stories from their members.*

B2.2. Transition from fee-for-service system to pay-for-performance system in the Medicaid program.

B2.2.1. Incentivize providers to follow best practices for the provision of care.

B2.2.2. Monitor health outcomes through standardized tools and measures, i.e., HEDIS measures.

Medicaid: *DMS completed an analysis of the 2012 v. 2013 HEDIS measures, network adequacy, and built an ongoing strategy for assessing and improving the quality of managed care services delivered in the Commonwealth. DMS developed a written strategy that creates the framework for assessing the health outcomes, the quality and appropriateness of care being delivered, procedures that identify the race/ethnicity/primary language of each enrollee, continually monitors the MCOs for compliance, and arranges for an annual external independent review of the quality outcomes and timeliness of and access to services. The MCOs have shown improvement in the following areas: Adult BMI Assessment, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents, Immunizations for Adolescents, Breast and Cervical Cancer Screenings, Appropriate Testing for Children with Pharyngitis, Use of Spirometry Testing in the Assessment and Diagnosis, Uses of Appropriate Medical for People with Asthma, Asthma Medication Ratio, Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis, Follow-up Care for Children prescribed ADHD Medication, Diabetes Screening for People with Schizophrenia or Bipolar who are using Antipsychotic Medication, Diabetes Monitoring for People with Diabetes and Schizophrenia, Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia, Adherence to Antipsychotic Medication for Individuals with Schizophrenia, Postpartum care, Annual Dental visits, and Frequency of Ongoing Prenatal Care. Additionally, HEDIS measures have improved drastically in many areas. For well-child and adolescent visits, there has been an increase in number of visits for nearly all age groups. Access to Preventive/Ambulatory Health Services and Children and Adolescents' Access to Primary Care Practitioners is over 90% for almost all age groups. Annual Monitoring for Patients on Persistent Medications is over 90% for three of the four measured medications. The MCOs have also made vast improvements in Comprehensive Diabetes Care, showing progress in all but one area.*

B2.3. – Implement a national fingerprint background check program for prospective employees of long term care providers.

B2.3.1. – Collaborate with stakeholders to design a data system for registry and fingerprint-supported criminal history checks.

***Office of the Inspector General (OIG)/OATS**: OIG continues its collaborative efforts with stakeholders to design the KARES (Kentucky Applicant Registry and Employment Screening) portal. Phase I and Phase II design, coding and testing was completed in December 2013 which will allow long-term care providers to enter a prospective applicant's name and other identifying information to receive immediate feedback regarding whether the individual's name appears on an abuse registry and, if applicable, confirm whether the individual's professional license is in good standing. It will also allow long-term care employers to request a state and FBI fingerprint check on all new applicants. The Fingerprinting process will be conduct at OET Career Center across the state. As of May 12, 2014, the KARES portal was deployed as a PILOT system with Phase I and II components to a pre-selected group of Long Term Care providers. Percentage Complete: 90%. OATS continues to collaborate with OIG, OET, Kentucky Interactive (KI), Kentucky State Police (KSP) in the maintenance, testing and integration of new software enhancements and Code Fixes provided by the primary vendor for software development,. This collaboration with stakeholders will continue through May 2015 (end of grant period) and may continue into 2016 if the 5th year no-cost grant extension is approved by CMS.*

B2.3.2 – Establish links between Office of Inspector General and the Kentucky State Police for state criminal records checks and to the FBI database for national criminal records checks.

***OIG:** OIG signed a Memorandum of Agreement on June 18, 2012, which allows KSP to:*

- *Contract with third party vendors which will design a link to the automated interface from which state and national criminal history data will be shared by KSP with the KARES system, and otherwise upgrade KSP's computerized criminal history system; and*
- *Provide the Cabinet with 36,000 national criminal record checks that will be processed and paid for by the grant funds, resulting in no cost additional charges to long-term care employers until the agreed-upon number of checks have been processed.*

On August 24, 2012, KSP's Purchase Orders were sent to the vendors. Installation of fingerprint units was completed by March 2014 at 35 Comprehensive One-Stop Career Centers throughout the Commonwealth. The goal in the physical placement of these scanners is to provide no more than a 30-45 minute drive from any location in the Commonwealth for prospective applicants.

B2.3.3. – Seek enabling legislation to establish the national fingerprint check program and to make fingerprint checks mandatory prior to employment in a long term care setting.

***OIG:** During the 2012 regular session of the Kentucky General Assembly, two identical measures (SB 175 and HB 250/HCS) were filed in an effort to fully implement the National Background Check Program grant and make fingerprint checks mandatory for prospective employees in long-term care settings. Neither bill passed in 2012.*

During the 2013 regular session, HB 73, was filed in a second attempt to make fingerprint checks mandatory for prospective employees in long-term care settings. Because this legislation did not pass, the OIG filed 906 KAR 1:190 on June 13, 2013 which was adopted December 10, 2013 to establish procedures for the implementation of KARES as a voluntary program. KARES remains a voluntary program because legislation seeking mandatory participation by long-term care facilities was also not successful in 2014.

Efforts are underway to propose legislation in 2015 to require fingerprint checks for prospective employees of long-term care facilities and other providers.

***OIG** continues its collaborative efforts with stakeholders to deploy the KARES. On May 12, 2014 the KARES PILOT System was deployed to a limited number of providers.*

***OATS,** working with the OIG, will support the Pilot system rollout by providing technical resources and skill to maintain the critical components that support the KARES web portal including:*

- *Kentucky Online Gateway (KOG) new user account management*
- *Network Support for the Fingerprint Scanners,*
- *Network Support for the Kentucky State Police and Kentucky Interactive (KI) Billing interfaces*
- *System Maintenance relating to new software enhancements and Bug fixes Program and Grant Management*

B2.4. Increase dental services for Kentucky's children.

B2.4.1. Provide 10% of the existing dental workforce with specialized dental training in FY2012.

***DPH:** In FY2012, there were 67 general dentists trained, which is approximately 4% of the workforce. The department also trained 38 hygienists.*

B2.4.2. Increase by 20% the number of assessment and varnish services to children under age six by local health departments in FY2012.

***DPH:** Data from FY2012 and FY2013 is pending. Early results indicate that FY2013 had 2.5 times more assessment and varnish services completed than FY2012, indicating the success of this program at the local level. Five health departments were awarded $160,000 each (Jessamine, Lawrence & Pike counties, and Lincoln Trail and Purchase Districts) to fund a public health dental hygiene program (full-time dental hygienist and assistant; portable dental equipment to set up two treatment areas; a transport vehicle; transportation costs, and dental supplies).*

B2.5 Coordinate the revision of Kentucky's Olmstead Compliance Plan.

B2.5.1 Complete revisions by January 30, 2014.

***OHP**:* OHP has conducted meetings with the Olmstead Planning Team and is finalizing stakeholder input in the Olmstead Compliance Plan.

B3 Improve consumer access to information about health, health care quality, and the health insurance marketplace.

B3.1. Analyze the Kentucky health insurance marketplace and analyze options and cost of technology solutions regarding health benefit exchanges.

B3.1.1. Optimize federal funding to conduct planning and analyses.

***OATS/KOHBHIE:** Beginning in September 2010, the Cabinet successfully secured federal funding for*

planning and analysis activities related to the Health Benefit Exchange (HBE) Project known as kynect. Federal funds were awarded to move forward with the project, and in January 2013, the Cabinet was awarded $182,707,738 in federal funds to establish of a state based health insurance exchange.
The Kentucky HBE contact center was implemented in August 2013 to assist Kentucky citizens with questions surrounding the health insurance exchange and Medicaid expansion. Kentucky's state based exchange went live on October 2013 and was fully operational July 1, 2014. As of April 2014 over 400,000 individuals have utilized the state exchange to enroll or re-enroll in health care coverage. The second open enrollment period will begin on November 15, 2014. The Exchange is correcting technology issues before the second open enrollment, and is developing an outreach campaign to increase enrollment for those still uninsured.

B3.1.2. Collaborate with states and federal government on information technology to leverage innovations and proven solutions.

OATS/KOHBHIE: *Through a competitive bid process, the Cabinet awarded a contract for the development and implementation of Kentucky's Health Benefit Exchange (HBE) IT solution. HBE also leveraged federal programs for risk and reinsurance, and the federal hub for individual information verification. The build and implementation process of the HBE solution is an ongoing success.*

The Cabinet is continuing to work on an integrated eligibility and enrollment system that includes the eligibility determinations for other human services programs, including the Supplemental Nutrition Assistance Program (SNAP), the Temporary Assistance for Needy Families program (TANF), the Women, Infants and Children program (WIC) referral process, the Low Income Home Energy Assistance program (LIHEAP), and Medicaid Waiver programs. Accomplishment of this goal will enable Kentucky citizens to apply on-line at one time for insurance affordability and all of the above named human services programs.

Planning funding of $150,000 for an All Payer Claims Database (APCD) was approved in August 2012 through HBE's Exchange Establishment Grant and additional funding is being sought for the remainder needed. These funds have a 90% federal/10% state match requirement and will be used to support analysis and planning across the HBE, the Kentucky Health Information Exchange (KHIE) and Medicaid Management Information System (MMIS) with a goal of identification of possible elements of shared infrastructure.

B3.1.3. Analyze system and information technology needs for communications across departments and programs.

OATS/KOHBHIE: *The Kentucky Health Benefit Exchange planning efforts have brought together several organizational units within the Cabinet (Office of Health Policy, KOHBHIE, Department for Medicaid Services, Department for Community Based Services, Office of Administrative and Technology Services) as well as the Kentucky Department of Insurance to assure the design of the HBE incorporates all necessary functionality in a unified solution. All of these partners continue to play prominent roles in the continuing activities surrounding the continued development of the HBE and have been actively involved in ongoing system design and implementation. The HBE will continue to work with other CHFS departments as other program eligibility determination and enrollment is onboarded into the system. Additionally, the HBE will work with the Department of Insurance regarding insurance issues that may affect both agencies.*

The KOHBHIE has procured kynector entities to assist individuals and small businesses in comparing

different coverage options available through the Kentucky HBE (kynect), and facilitate enrollment. The Health Benefit Exchange was fully operational January 1, 2014.

***OATS**: A key component of the Quality Health Infrastructure is the implementation of standards and software tools that will allow the connection of the various data stores within the Cabinet. Tools such as master data management software will tie citizen and provider records in disparate systems together to allow cross system analysis. These tools have been implemented in the new Eligibility and Enrollment System, are required for replacement MMIS system, and will be required of all new systems and major modifications in the future. The development of an enterprise Data Analytics framework will begin with the development of the All Payer's Claims Data Base (APCD). APCD will be the first data store to be positioned within our Data Analytics framework. As the project continues we will add additional data stores from Medicaid, Child Support, Health Information Exchange, DCBS, and others creating a Cabinet level analytics capability.*

B3.2. Provide information to consumers on quality indicators for health care services.

B3.2.1. Identify and use tested products that provide indicators of quality care, utilization, avoidable stays related to hospitals.

B3.2.2. Expand to other types of health care services when technology is available.

B3.2.3. Develop web-based data to display quality data

***OHP:** This goal is 100% complete. MONAHRQ a software product developed by the federal Agency for Healthcare Research and Quality (AHRQ) to create webpages to display inpatient hospital quality indicators, utilization, and avoidable stays was utilized beginning June 2011. Kentucky was the 4th state to implement this product. Currently, data for calendar years 2009, 2010, 2011 and 2012 are displayed. In early Fall 2014, the 2013 data will be available to the public.*

B3.3 Maintain a chronic disease information program for individuals with disabilities, aging individuals, and caregivers.

B3.3.1. Continue training to all area development.

B3.3.2. Enroll 800 adults and caregivers in a six-week course on disease management.

***Department for Aging and Independent Living (DAIL):** The Stanford Chronic Disease Self-Management and Diabetes Self-Management Education Programs are currently being offered in Kentucky. A chronic disease information program has been provided to all Area Development Districts. As of August 18, 2014 there have been 3493 Kentuckians who have participated in a six-week course on disease management, with 2,541 (81.6%) completing the course.*

***DPH**: The Kentucky Diabetes Prevention and Control Program has been active in a variety of efforts to promote/support the Diabetes Prevention Program (DPP). The Department was successful in obtaining a grant from the National Association of Chronic Disease Directors to expand their work with the DPP in Kentucky. There are currently 18 Centers for Diseases Disease Control and Prevention (CDC) DPP sites in Kentucky and Cincinnati. The DPPs that have completed 12 or more sessions have reported an average client attendance of 88%; average weight loss of 11 pounds; and average physical activity of 110 minutes per week. There are five new DPP sites planned for Fall 2014.*

C. Enhance Educational Excellence

C1. Provide opportunities for early intervention, early learning, and quality child care so children are healthy and ready to learn.

DCBS: *The Department and its contractor, the University of Kentucky's Human Development Institute, provide technical assistance to the state's Quality Rating and Improvement System (QRIS) for child care (a.k.a., STARS for KIDS NOW), the Kentucky early care and education trainer credentialing system, and individual child care programs in an ongoing effort to increase the number of high quality service providers.*

- *A total of 4,793 child care facilities received STARS technical assistance, which included 3,225 technical assistance contacts in State Fiscal Year (SFY) 2014.*
- *The number of child care professionals better prepared to meet the educational needs of children has increased as the result of enhanced opportunities for professional development. As of June 30, 2014, the Early Care and Education Training Records Information System (ECE-TRIS) is tracking the training records of 74,145 early care and education professionals. Seven hundred and sixteen (716) individuals have a Kentucky Early Care and Education Trainer Credential, 1,632 Individuals have a Kentucky Director's Credential, and 923 Individuals have a Commonwealth Child Care Credential.*

The Child Care Assistance Program (CCAP) promotes, expands and improves the quality of care for children in Kentucky and ensures that families most in need are aware of and have access to available, quality child care which is developmentally appropriate, affordable and safe.

The approach to service delivery combines the efforts of DCBS and other service providers and partners to address a family's needs in a comprehensive fashion, thereby maximizing the likelihood that a family will achieve positive outcomes. Children with special needs and children receiving protective services are priority populations. Temporary Assistance for Needy Families (TANF) recipients and persons transitioning off TANF are also eligible for child care assistance. During SFY 2014, the average number of families served in CCAP was 15,231/month.

DCBS contracts with the Cabinet's Office Inspector General (OIG) to inspect, monitor and license center-based providers and inspect, monitor and certify family child care home providers. Additionally, the STARS for KIDS NOW Program is part of Kentucky's Early Childhood Initiative and is a voluntary quality rating system (above and beyond licensing requirements) that places major emphasis on raising the quality level of early care and education in child care available to Kentucky families. Targeted quality set-asides under CCDF are being utilized to promote and improve the quality of infant/toddler training opportunities, enhance professional development activities, improve education in child care programs, improve child and staff interactions, increase parental involvement, and facilitate regulatory compliance to all child care programs.

C1.1 Increase early literacy and numeracy outcomes in the First Steps Program.

C1.1.1. At least 60% of children who enter the program below age expectation will substantially increase literacy and numeracy skills by age three or when they exit the program.

C1.1.2. At least 40% of children will function at age expectation by age three or when they exit the program.

DPH: *First Steps measures and reports child outcomes annually. During the past year, emphasis in training has been on developing functional Individualized Family Service Plan (IFSP) goals, conducting quality family assessments and aligning service plan goals to the child outcomes. Comprehensive program audits were conducted on all fifteen (15) Points of Entry (POEs) resulting in focused technical assistance and training on the specific areas of weakness. First Steps issues yearly determinations of performance based upon the Part C State Performance Plan. In FY14, five of the POEs made substantial improvements with three of those POEs attaining "Meets Requirements". First Steps as a statewide system maintained a "Meets Requirement" determination when assessed by the US Department of Education.*

DPH: *Summary Statements*

Outcome A: Positive social-emotional skills (including social relationships)

	Baseline FFY08 (% of children)	*Targets FFY12*	*Actual Results FFY12*
1. Of those children who entered the program below age expectations in Outcome A, the percent who substantially increased their rate of growth by the time they turned 3 years of age or exited the program	*70.1*	*80*	*90*
2. The percent of children who were functioning within age expectations in Outcome A by the time they turned 3 years of age or exited the program	*48.1*	*62.5*	*73*

Outcome B: Acquisition and use of knowledge and skills (including early language/communication and early literacy)

	Baseline FFY08 (% of children)	*Targets FFY12*	*Actual Results FFY12*
1 Of those children who entered the program below age expectations in Outcome B, the percent who substantially increased their rate of growth by the time they turned 3 years of age or exited the program	*61.8*	*85*	*93*
2. The percent of children who were functioning within age expectations in Outcome B by the time they	*28.8*	*57.5*	*75*

turned 3 years of age or exited the program

C1.2. Increase the number of diagnostic evaluations for infant hearing loss.

Commission on Children with Special Health Care Needs (CCSHCN): *In FY 2013-14, 717 infant diagnostic evaluations were conducted during non-medical clinic encounters by CCSHCN audiologists. State of the art equipment enables audiologists in 11 of 12 district offices to offer infant diagnostic evaluations to infants who refer on their newborn hearing screening or who present with risk factors for progressive or late onset hearing loss. In addition, CCSHCN has entered into a collaborative relationship with an otolaryngologist in the Prestonsburg area and now offer sedated ABRs to older infants and toddlers who require this approach for a definitive diagnosis. Statistics reveal that approximately 3/1000 infants are born with permanent hearing loss. By age 6, the incidence of permanent childhood hearing loss is 6/1000. The CCSHCN designation as the primary audiology provider for First Steps resulted in referrals for 1175 hearing evaluations in FY 13-14. All 12 CCSHCN district offices routinely receive referrals for hearing evaluations from First Steps staff and audiologists document test findings and plan of care in the First Steps data base.*

C1.2.1. At least 75% of infants referred following a failed hearing screening will have a diagnostic evaluation.

(CCSHCN: *The Commission's exceeded this target with a CDC data submission for 2012 of 86.9%. Our goal is to maintain a 98% hearing screening rate by birthing hospitals and to improve the rate of warranted, timely diagnostic evaluation by 2.5% per year for the next 3 years.*

C1.2.2. Formalize interagency partnerships to increase the number of quality service providers.

CCSHCN: *contracts with DPH First Steps (FS) through a Memorandum of Agreement to be the primary audiology provider for FS and in providing Otoacoustic Emission (OAE) equipment and training to Point of Entry (POE) staff. Hearing screening test results have been received from First Steps on 432 children CCSHCN is the primary audiology provider for children in the custody of DCBS. These initiatives reduce loss to follow-up numbers by capturing information on children with a history or diagnosis of hearing loss which is shared in a HIPAA compliant format. CCSHCN performed 8 diagnostic hearing evaluations on First Steps recipients in 2010, prior to the implementation of the MOA with FS. To date, CCSHCN has performed 3,595 evaluations as a result of FS referrals since the inception of the MOA.*

CCSHCN has contracts with 12 Kentucky school systems to provide audiology services and Durable Medical Equipment (DME) for children diagnosed as having permanent childhood hearing loss. Services provided through this program are supplemented by the School Audiology Services program and enable school systems to refer difficult to test children or children diagnosed with permanent hearing loss to CCSHCN audiologists for evaluation and treatment. In FY 13-14, 190 children were referred to district offices for testing and intervention services.

CCSHCN audiologists are reaching out to Head Start and Early Head Start programs to offer assistance with implementation of enhanced hearing screenings protocols, with the aim of reducing loss to follow up

and improving timeliness of provision of medical or audiological management when warranted. CCSHCN already has collaborative relationships with several programs in the Louisville, Barbourville and Ashland regions. Audiologists will train school staff on hearing screening techniques and work with school staff on site to assist in providing follow up hearing screenings on children who refer on initial screening. Very few educational audiologists are employed by Kentucky school systems; use of CCSHCN audiologists a void in the implementation of effective hearing conservations programs in districts where the need is greatest.

Eleven (11) of 12 CCSHCN office now offer comprehensive diagnostic services including infant auditory brainstem response and are designated as "Level II" Centers on the EHDI Audiology Providers resource list. CCSHCN receives EHDI referrals from KY birthing hospitals to all district offices. The Commission partners with a large number of agencies and audiological providers, including 23 "Level I" centers" and 16 "Level II" centers. Informal partnerships exist with many other providers to whom CCSHCN provides technical assistance and from whom CCSHCN receives data.

CCSHCN is in the process of refining the "EHDI Audiology Providers" resource given to consumers/parents/physicians. This document is designed to assist in scheduling diagnostic follow up as a result of a newborn hearing screening indicating a refer on one or both ears or identification of risk factors for progressive hearing loss. In addition, a query will be constructed to determine if non-CCSHCN audiology providers designated as "Level II" centers are actually performing the full complement of diagnostic testing on infants referred to their center. CCSHCN plans to develop an "Audiology Score Card" on the basis of these findings and will implement a "get well program" for centers that are not consistently providing their designated level of diagnostics.

CCSHCN has established an inter-account process in collaborating with the Office of Vocational Rehabilitation (OVR) to provide audiology services and DME (including FM systems) on behalf of individual CCSHCN patients who also receive services through OVR.

An agreement with the University of Louisville allows graduate students in Audiology to obtain supervised clinical practicum hours working with CCSHCN audiology patients in district offices.

D. Ensure Safe Communities

D1. Promote, protect, and preserve the dignity and well-being of individuals and families.

D1.1 Increase the capacity of the state to respond to emergency or crisis situations.

D1.1.1. At least 75% of Kentucky's local health departments will have an emergency operations plan.

DPH: *As of June 30, 2013, the following percentages of local health departments in Kentucky submitted emergency operations plans to KDPH:*

- *98% of Strategic National Stockpile (SNS) Plans*
- *98% of Emergency Support Function 8 Health and Medical (ESF-8)Plans*

- *98% of Continuity of Operations Plans*

D1.1.2. All health department emergency responders will be trained to Tier I level.

DPH: *As of June 30, 2014, 95% of health department responders are trained to the appropriate Tier level, which includes Tiers 1, 2, and 3.*

D.1.1.3 The Department for Public Health will conduct and evaluate a staff assembly drill during 2014.

DPH: *The Preparedness Branch conducts a no-notice staff assembly drill at least once per year and documents the findings in an After Action Report/Improvement Plan. The most recent drill was successful with Incident Management Lead Roles for the Incident Command Structure of the Kentucky Department for Public Health fully staffed within 20 minutes of the initial alert. This drill successfully demonstrated the ability to use an alternate location for the Operations Center.*

D1.2 Enhance permanency for children in the state's custody

D1.2.1. Through data monitoring, develop regional action plans that reduce the number of placements a child experiences.

DCBS: *Each of the DCBS nine Service Regions in Kentucky, serving 120 counties, has created a plan to improve the placement stability of children in foster care. DCBS Central Office has worked to coordinate recruitment and training of foster parents who best match the child's needs at initial placement to reduce the need for placement changes. Federal measures for placement stability are prescribed as a condition of continued federal funding.*

Between July 2011 to July 2013, Kentucky proved to be a top performing state in two of the three categories of Federal data: Percentage of children in care less than 12 months with 2 or fewer placement (avg. 88.8%) and Percentage of children in care 12 to 24 months with 2 or fewer placements (avg. 65.3%). For the third category of Federal data, Percentage of children in care for at least 24 months with 2 or fewer placements, as compared to other states, Kentucky falls within the mid-range performers (avg. 35.9%).

Each of the DCBS Service Regions now have Out-of-Home Care or Permanency Specialists who become involved in instances where placement resources are proving difficult to find for a specific child or children. Additionally, a plan was implemented in 2013 to hire staff at the state level to ensure compliance with the Adoptions and Safe Families Act (ASFA), Indian Child Welfare Act (ICWA) and to work with the regional Out-of-Home Care or Permanency Specialists to enhance permanency efforts statewide. These staff members began work with DCBS in January 2014.

Further, in late fall of 2013, DCBS began discussions on directing a team of staff to work in the role of case managers to assist in discharge planning for children identified as difficult to place. Generally, these children are in acute care psychiatric hospitals, children with extreme behaviors for which local staff could not identify placements and children who are medically fragile with challenging behavioral health issues or with type one diabetes and challenging behavioral health issues.

Beginning in January of 2014, the Placement Safety Team, which includes a licensed clinical social worker, two seasoned child welfare workers and a nurse with experience in the child welfare setting, at both the local and central office level, began working to provide placement support to the service regions. This process produces close collaboration between Central Office and Regional staff, including the supervisors and child welfare workers for children, based upon the medical or hospital discharge model, involving potential placement agencies, the child's assigned Medicaid Managed Care Organization and other stakeholders in the case.

To promote continued efforts to focus on placement stability, the regions receive region specific data, by county, on a monthly, quarterly and annual basis to provide feedback regarding placement stability. Several conditions factor into placement stability, for example, diligent recruitment of foster homes to meet the needs and characteristics of children entering care, consistent home visitation, support of the families, caretaker needs and proximity of placement. For the period of 08/01/2013 to 07/31/2014, 6,781 (53.3%) children had 2 or fewer moves (1 move).

D1.2.2. – Increase by 5% the number of statewide partners participating in the Community Collaborations for Children regional networks.

DCBS: *In State Fiscal Year (SFY) 2011, 148 community partners attended Community Collaborations for Children (CCC) regional network meetings. In SFY 2012, 189 community partners attended the CCC regional network meetings as recorded in the attendance tracking system; an increase of nearly 28%.*

In State Fiscal Year 2013, 1,243 community partners attended CCC regional network meetings.
During State Fiscal Year 2014, approximately 1,685 community partners attended CCC regional network meetings; an increase of nearly 36%. In prior years a decline in regional network participation had been observed; however, community partner attendance and participation in the regional network meetings appears to now be increasing, as the critical need for sharing local resources has become more of a necessity.

TA's report shows that the networks have witnessed a decline in community partner participation due to budget constraints and are discussing the issue. Some agencies have cut back on the number of representatives that they can send to meetings or the number of meetings that they can attend. Coordinators continue to reach out to community partners to encouraging participation.

D1.3. Improve the understanding of health care professionals about the effects of traumatic events on individuals in order to maximize the efficacy of behavioral and physical health care interventions.

D1.3.1. Create a department-wide team to develop policy on "trauma-informed" care for the behavioral health and developmentally disabled populations.

DBHDID*: A multi-agency Trauma-Informed Care Steering Committee that includes Dept staff was developed and continues to meet 3 times per year to network, discuss best practices and new initiatives associated with trauma-informed care. Approximately 15-20 different agencies participate on this committee. The meetings were held on 9/16/13, 1/13/14, 6/23/14.*

D1.3.2. Create curricula and conduct training to increase awareness and enhance the effectiveness of "trauma-informed" care.

DBHDID: *A curriculum has been developed for "training for trainers". An overview of trauma-informed care continues to be presented in a "Training for Trainers" format and provided to trainers within a variety of agencies. This training is held on an as-requested basis and is free to participants. One training was held in SFY 2014 (1/9/14). Approximately 32 trainers were trained across 20 community agencies.*

D2. Assure that services delivered by providers meet applicable health and safety standards.

D2.1. Improve inspections and surveys of health care facilities

D2.2.1. Conduct specialized in-depth training for complaint/incident investigations for all surveyors.

OIG: *The Division of Health Care conducted the following trainings to meet this objective:*

1. *Surveyor training on Complaint Investigations, Frankfort – August 15-16, 2011*
2. *Surveyor training on Advancing Excellence in Long Term Care Facilities, Lexington- October 24-26, 2011*
3. *Surveyor training on Complaint Investigations, Louisville- August 27, 2012*

D2.2.2. Ensure available nurse regulator positions are filled.

OIG: *The OIG has filled eight nurse regulator positions throughout its four regions. Although the OIG has experienced turnover in the nurse regulator positions, the OIG continues its efforts to retain two nurse regulators in each region.*

D2.2.3. Continue to conduct trainings for staff of long term care facilities.

OIG: *The OIG's Division of Health Care conducted the following trainings to meet this objective:*

1. *Long term care facility staff training on Minimum Data Set 3.0 Basics Training. Louisville, August 7-8, 2014. Long term care facility staff training on Making it Stick: Involving Everyone for Continuous Improvement, Louisville, August 27, 2014.*
2. *Long term care facility staff training on Minimum Data Set 3.0 Advanced Training, Louisville, November 3, 2014.*

D.2.2.4. Implement the federal Quality Indicator Survey process for Medicaid/Medicare certified long term care facilities.

OIG: *The Centers for Medicare and Medicaid Services placed states on hold to implement the Quality Indicator Survey (QIS) in order to review the QIS survey process but now plans to allow additional states to move forward . To prepare for the eventual implementation of the QIS survey process, the OIG is continuing with preparations, including a collaborative effort with Florida, and has provided the following*

trainings to meet this objective:

1. *New employee surveyor training on tablet computers and introduction to electronic survey forms-Frankfort,*
    a. *2011 - August 8, 22, September 19, October 17, November 14, December 5*
    b. *2012 - January 23, February 20, March 19, April 16, 23, May 10, 21, June 25, September 17, October 22, December 18.*
    c. *2013 - January 15, March 19, April 16, May 21, July 23, August 19, September 24.*
    d. *2014 – January 17, February 17, March 19, May 19, June 16, July 21, September 15.*

2. Surveyor training webinar on the revised QIS Critical Element Pathways – Frankfort, February 17, 2014.

D3. Enhance the use of technology to address substance abuse.

D3.1. Enhance the use of the Kentucky All Schedule Prescription Electronic Report system (KASPER) to monitor controlled substances.

D3.1.1. Maintain or increase the number of account holders participating in KASPER.

OIG/OATS: *One of the key components of HB 1 from the 2012 Special Session of the Kentucky General Assembly was the implementation of a new provision in which all practitioners and pharmacists authorized to prescribe or dispense controlled substances are required to obtain a KASPER account. Approximately 18,000 providers have signed up for a KASPER account since the passage of House Bill 1, representing an increase of 224%.*

While steady increase of KASPER master accounts occurred through outreach, promotion and training, the passage of House Bill 1 has increased this number exponentially.

- *On 12/31/11 a total of 7,545 Physicians, APRNs, and Pharmacists held master accounts.*
- *As of 08/22/2012, one month after HB1 took effect, a total of 20,389 Physicians, APRNs, and Pharmacists held master accounts.*
- *As of June 30, 2014, a total of 25,677 Physicians, APRNS, and Pharmacists held master accounts.*

The increase in KASPER master accounts has resulted in significant growth in reports requested. The weekday average number of KASPER reports requested during 2011 was 2,888. The current weekday average is 17,895, a 520% increase. In 2011, approximately 811,000 KASPER reports were requested by authorized users. For 2012 the number of reports increased to approximately 2.67 million reports and for 2013 to approximately 4.58 million reports. OATS estimates that over 5 million reports will be requested during 2014.

D3.1.2. Develop criteria for trigger reports on prescribers.

OIG: *Governor Beshear appointed an 11-member KASPER Advisory Council (KAC) in the fall of 2011 to develop recommendations that will enhance the KASPER program's ability to focus on potential problem areas and proactively generate information that may be used by professional licensing boards to identify practitioners who may be engaged in prescribing controlled substances improperly or illegally. KAC has met 11 times and reviewed de-identified KASPER trend data to determine appropriate thresholds to identify prescriber outliers. Such outliers are subject to a specialized prescriber review conducted by the OIG, which reports potential problem prescribers to the appropriate licensure board and law enforcement upon*

completion of the specialized review.

***OATS** continues to coordinate with OIG and the KASPER Advisory Council (KAC) to identify triggers for potentially inappropriate prescribing of controlled substances. During calendar year 2013 and to date the KAC requested that OIG and OATS focus on top prescribers in different provider types, review overall prescribing of stimulants and for the first time gather data related to pharmacies. With guidance from the OIG OATS compiled prescribing data for dentists for benzodiazepines, oxycodone, and hydrocodone. Additionally, prescribing data was compiled for all prescribers of stimulants as well as the dispensing of all controlled substances by pharmacies.*

D3.1.3. Increase the distribution of unsolicited KASPER reports.

***OIG:** Kentucky law requires all practitioners authorized to prescribe controlled substances to register for a KASPER account and query the system under certain circumstances. Requiring a practitioner to query KASPER prior to the initial prescribing of schedule II controlled substances and schedule III controlled substances with hydrocodone may make the issue of unsolicited patient reports unnecessary.*

As authority for unsolicited patient reports is still not provided for in the statutes, the OIG and OATS have shifted priorities to focus on prescriber compliance in querying KASPER as mandated by legislation. Those prescribers identified to have not complied with the law will be referred to the appropriate licensure boards.

***OATS:** OATS staff members in coordination with OIG have developed database queries which will proactively utilize KASPER data to identify prescribers who may not be complying with the law and not querying KASPER as required.*

E. Enhance Responsible Governance

E1. Increase energy efficiency of cabinet owned or operated facilities.

E1.1. Reduce energy consumption in state buildings by 15 percent by 2015.

***OATS:** CHFS has a very proactive approach to reducing Energy consumption. As a result the Cabinet is currently experiencing annual Energy consumption reduction in excess of 20%.*

E1.1.1. Continue collaboration with Finance Cabinet on the Commonwealth Energy Management and Control System (CEMCS).

E1.1.2. Continue energy savings and performance contracts with cabinet owned or operated facilities.

***OATS:** CHFS continues to be highly involved in the CEMCS Project and worked with the Finance Cabinet to expand CEMCS to the newly constructed Eastern State Hospital and Glasgow State Nursing Facility. These are the first new buildings designed and constructed with CEMCS integration as part of the original design scope. CHFS is currently reviewing the energy consumption of the remaining campuses in order to determine the next site for expansion of CEMCS. This next round of ESPC Projects is very feasible based on the technological advances in energy savings equipment and controls.*

Numerous energy management upgrades were installed at the Central State Hospital and Hazelwood campuses and are being fine-tuned. The documented savings for the Central State Hospital and Hazelwood campuses now exceeds $475,000. In fiscal year 2014, overall energy consumption is down by 12.4% and cost is down 14.1% versus the 2009 baseline energy usage.

DBHDID campus properties have undergone Energy Savings Performance Contracts (ESPC). The most recent was completed earlier this year at the Outwood and Caney Creek campuses. The year one Measurement and Verification Audit shows the Outwood and Caney Creek ESPC Project exceeded the guaranteed savings by more than $3,400.

The Cabinet has more than $1.5 million in gross annual savings as a result of completed ESPC projects.

The Energy Management Program in expanding into Cabinet leased properties as well and is reviewing all construction and renovation projects to assure that energy savings is always a priority in all projects. A prototype of a wireless portable Building Controls System has been successfully installed in one of the Cabinet's largest leased offices.

E2. Increase the use of electronic resources to enhance efficiencies and avoid redundancies.

E2.1. Continue process improvement with the Office of Administration and Technology System's Economies and Efficiencies initiative throughout the cabinet.

OATS: *Despite limitations on personnel resources, OATS has continued to find areas where processes can be improved upon.*

- *Division of Accounting and Procurement Services*
    - *Developed reports in Information Advantage for most federal reports which resulting in the elimination of one (1) day of work per Grant Accountant.*
    - *Developed an updated report for the annual SEFA report. This report eliminated a week of work for those employees responsible for the reporting.*
    - *Developed updated queries for the Closing Package. This eliminated a significant time in the preparation of the yearly closing package.*
    - *A new webpage containing instructions to assist requesting agencies when making non-IT temporary staff requests was launched. The webpage provided step-by-step instructions and pertinent information to help agencies determine need, select a vendor or position title, etc. It also contained the necessary forms and and checklists for requesters to use that guided them through the process. This tool reduced the amount of questions, reduced the number of rejected requests and provided the employee hired to do this job function when the previous employee left to take another position.*
- *Division of Facilities Management*
    - *Asset Tracking Processes – The Procurement, Payables, and Asset Tracking System (PPATS) was developed and implemented in July 2011. PPATS implementation along with the Distribution Center has resulted in a $1.6 million dollar decrease in missing equipment. Additionally, the Commonwealth Office of Technology has made the*

PPATS an Enterprise System with implementation on December 5, 2013 used state-wide for asset tracking purposes.

- *Insurance Processes – All "as-is" processes have been documented. "To Be" processes are being identified and documented.*
- *Records Management Processes – All "as-is" processes have been documented. "To Be" processes are being identified and documented.*
- *PPATS contains a public module for Kentucky State Police (KSP) access allowing KSP to access building plans in cases of emergency, disaster, etc. to identify egress or access methods. The Leased Properties Team is working to complete "as-built" floor plans for all CHFS occupied buildings. This project is approximately 30% complete.*
- *Construction Inspections, Leased Property Information and Processes- PPATS contains a Leased Properties Section in which all data relative to a CHFS leased property may be maintained, including inspection information. The "as-is" processes are being documented and are currently 25% complete. This project is currently on hold but is expected to restart within the next 12 months.*

- *OATS Security and Audit Section*
  - *COT Billing – gathered business processes and are working to complete scope definition, As-Is detail, and To-Be detail documentation (15% complete)*

E2.1.1. – Identify and eliminate redundancies in business processes.
E2.1.2. – Integrate data sources for more timely information.
E2.1.3. – Document cost avoidance and other outcomes.
E2.1.4. – Develop technology platforms and applications for staff to be mobile and productive.

OATS: *The Economies and Efficiencies project has been able to eliminate redundancies in several areas so that only electronic documentation is maintained and attached within the state accounting system instead of printing and filing hard documents.*

The Economies and Efficiencies project developed and implemented PPATS, replacing internal hard copy forms for the Transfer and Disposal of assets and combining three separate tracking databases that were utilized and also assisted in review of the COT billing process so that files are now received electronically for more accurate and timely review. Additionally it made the following possible:

- *Grants Management Branch in reconciling CHFS grants and identifying Federal draws that have not been completed.*
- *Fixed Asset Branch (utilization of PPATS) to reduce lost inventory and enabled the creation of a distribution center.*
- *COT Billing completed a Telecom Audit project with Avalon which started in March 2012 and has discovered telecom charges that were not being used and charges that did not belong to the Cabinet for Health and Family Services.*
- *Creating an application that will assist Draw Accountants with the calculation and reconciliation of daily Medicaid draws.*

NOTE: Beginning FY14, PPATS was subsumed by the Commonwealth Office of Technology (COT) to be used as an Enterprise tool.

E3. Increase the use of information technology to support transparency and accountability.

E3.1 Replace the Kentucky Automated Management and Eligibility System (KAMES) with an integrated system that will accept applications via internet and link to other major Cabinet information systems.

OATS/DCBS/KOHBHIE: *KAMES is a 20-year-old legacy mainframe system. It is labor, time, and cost-intensive to maintain and uses COBOL computer language, which is no longer widely used. The new Eligibility Systems Integration Services (ESIS) will devise a flexible model for implementation of eligibility determination rules, which will allow for greater ease in the future in implementing rule changes resulting from new regulatory or legal mandates. This project is being built on existing Health Benefit Exchange/Medicaid Eligibility System functionality.*

The ESIS project was approved in October 2013 by the Capital Projects and Bond Oversight Committee. This new capital information technology project will enhance the foundational components of the new Medicaid Eligibility System to integrate other health and human services programs that serve a large common population. These additional programs include: Supplemental Nutrition Assistance Program (SNAP aka Food Stamps); Temporary Assistance for Needy Families (TANF); Women Infants and Children (WIC) Food Program; Low Income Home Energy Assistance Program (LIHEAP); and Medicaid Waiver programs.

Implementation of the new system is planned for December 2015.

E4. Enhance business practices to maximize resources.

E4.1 Enhance the child support collections with information technology.
E4.1.1. Increase the number of vendors submitting electronic records.
E4.1.2. Continue development of online resources for easy access by staff.

DIS/CSE: *To date, Child Support Enforcement (CSE) has had a total of 25,835 on-line payments made since implementation of the customer service web portal.*

Business Intelligence (BI) tools implemented February, 2012 provides CSE with performance reports and dashboards to enable the program to monitor and improve performance at the caseworker level. Additionally, BI provides predictive analytics assisting staff in prioritizing their work and customizing the enforcement techniques utilized to collect support.

CSE has seen an increase of 21% in the number of employers signed up to use Electronic Fund Transfers (EFTs). CSE implemented the Child Support Customer Service Web Portal February 2012. The portal allows parents the ability to access their account online and make payments as well as submit applications for service.

To date CSE has had 4,601 applications submitted, 11,044 accounts have been created and 25,835 payments have been made. CSE online policy and procedures manual rolled out in May, 2013.

OATS: *The Kentucky Automated Support and Enforcement System (KASES) staff is currently working on completion of the Child Support Modernization Projects including: The Child Support Online Policy and Procedures Manual, The Child Support Electronic Case File and Jefferson County transition to KASES. These projects have been taken in house and staff is currently working on Electronic Case File and Jefferson County transition to KASES.*

Policy and Procedures Phase I and II, the Online Manual and Change Request, have been implemented. Child Support Enforcement now has the capability to view and search the current and historical versions of the approved and published P&P chapters. Through the Change Request process there is the ability to create, assign, attach documents, and track (via dashboard) change requests with a simplified process to solicit, gather, and track comments from workers across the state. Phase III, Question and Answer, is currently on hold.

The Electronic Case File is comprised of Phase IV, Core Functionality for scanning and imaging and Phase V Archival Functions. The Phase IV pilot is scheduled to be implemented in August 2014. The Statewide rollout of Phase IV is scheduled to start October 2014. Phase V is scheduled to be implemented the second quarter of 2015. This project includes the ability to image paper documents, insert documents and interface with external sources to import documents into the DMS repository. Users will be able to search and display documents.

The Jefferson County transition to KASES is under way. The Ombudsman, Cash Window and Arrearage Audit Tool peripherals have been implemented. Client Referral has been put on hold pending JCAO's analysis as to whether it is still needed. Jefferson County transitioning to KASES will eliminate the need to support two Child Support systems with interfaces between. Transition to KASES is planned for the Third quarter of 2014.

VIII. Strategic Plan Progress Report on Goals & Objectives Operable in the Last year - N/A